WILSON HEALTH
Caring Without Limits

# Patient Portal Proxy Access Request/Removal and Authorization

***Use this form for adult patients who wish to grant or remove proxy access to other adults or legal representatives for the Wilson Health Hospital patient portal. Minors between the ages of 12 and 17 may use this form for granting or removing proxy access to their legal representative for the Wilson Health Hospital patient portal

## 1. Patient's Information (All fields required – please print clearly)

Complete this section with the patient's information whose Patient Portal will be accessed by the proxy.

Name:____________________________________________ Date of Birth:____________________
(Last, First, Middle Initial)

Street Address:______________________________City:____________State:________ Zip:__________

Phone Number:____________________________ Email Address:________________________________

## 2. Adult/Legal Representative Proxy Information (All fields required – please print clearly)

Complete this section with the person's information you wish to grant access to your Wilson Health hospital patient portal.

Name:____________________________________________ Date of Birth:____________________
(Last, First, Middle Initial)

Street Address:______________________________City:____________State:________ Zip:__________

Phone Number:____________________________ Email Address:________________________________

## 3. Adult/Legal Representative Proxy Removal

☐ By checking this box I am submitting in writing that I wish all proxy to be removed from my account. If I wish for a particular individual to remain as proxy they must be indicated in box 2 above.

As the patient listed in this binding document I permit Wilson Health Hospital to release protected health/medical information through the Patient Portal to the designated represented in section 2. I understand that by permitting another person proxy, access to the Patient Portal, he/she will view the same information I may view myself.

I understand that once my records have been released to my proxy, they may be re-disclosed by the proxy and will no longer be protected by federal regulations.

I understand that protected health/medical information that is released through the Patient Portal to my proxy may include, but is not limited to treatment, diagnosis or testing of one or more of the following conditions: alcohol and/or drug abuse, physical and mental illness, AIDS, HIV test results, or visit history confirming that the patient was seen for one of these conditions.

I understand that I can terminate my authorization to release health/medical information to my proxy at any time by submitting this form with section 3 completed to Wilson Health Hospital. This termination of authorization will not apply to records that were released prior proxy was terminated. All requests will be filled within a reasonable amount of time.

| By signing below, I acknowledge that I have read and understand the Patient Portal Proxy Access/Removal and Authorization form and I agree to its terms. | By signing below, I acknowledge that I have read and understand the Patient Portal Proxy Access/Removal and Authorization form. I agree to its terms and understand that my proxy access can be revoked at any time by the patient or Wilson Health for any reason, including misuse of the Patient Portal by me. I acknowledge that I will be using my own Patient Portal account to access the patient's Patient Portal information, and that I will comply with the Patient Portal Terms and Conditions of Participation. |
|---|---|
| ____________________/__________ | __________________________/__________ |
| **Patient Signature: Date** | **Proxy Signature: Date** |